

Plan Year 2004 Comparison Chart

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network	Preferred Provider Organization (PPO) Preferred Health Systems
Deductible (not included in coinsurance maximums)	n/a	<u>Network</u> n/a <u>Non-Network</u> \$500 single/\$1,500 family	<u>Network</u> n/a <u>Non-Network</u> \$500 single/\$1,500 family
Coinsurance 1	10%	<u>Network</u> 50% <u>Non-Network</u> 50%	<u>Network</u> 50% <u>Non-Network</u> 50%
Coinsurance Maximum 1 (does not include deductible or copayments)	\$1,000 single/\$2,000 family	<u>Network</u> \$1,100 single/ \$2,200 family <u>Non-Network</u> \$1,450 single/ \$2,900 family	<u>Network</u> \$2,200 single/ \$4,400 family <u>Non-Network</u> \$3,650 single/ \$7,300 family
Coinsurance 2	n/a	<u>Network</u> 30% <u>Non-Network</u> 30%	<u>Network</u> n/a <u>Non-Network</u> n/a
Coinsurance Maximum 2 (does not include deductible or copayments)	n/a	<u>Network</u> \$1,100 single/ \$2,200 family <u>Non-Network</u> \$2,200 single/ \$4,400 family	<u>Network</u> n/a <u>Non-Network</u> n/a
Total Coinsurance Maximum (does not include deductible or copayments)	\$1,000 single/\$2,000 family	<u>Network</u> \$2,200 single/ \$4,400 family <u>Non-Network</u> \$3,650 single/ \$7,300 family	<u>Network</u> \$2,200 single/ \$4,400 family <u>Non-Network</u> \$3,650 single/ \$7,300 family
Copayment Summary - see specific category for detail on copayments.			
Physician Office Visit	\$20 PCP / \$30 Specialist	<u>Network</u> n/a (Coins. applies) <u>Non-Network</u> n/a	<u>Network</u> n/a (Coins. applies) <u>Non-Network</u> n/a
Outpatient Mental Health (Biologically Based)	\$25	\$25	\$25
Inpatient Services*	\$200 per admission	\$300 per admission \$600 per admission	\$300 per admission \$600 per admission
Emergency Room Visit*	\$75	\$100 \$200	\$100 \$200
Urgent Care Facility Visit	\$30	n/a n/a	n/a n/a
Outpatient Surgery*	\$100 per surgery	n/a n/a	n/a n/a
Major Diagnostic Tests*	\$100 per test	n/a n/a	n/a n/a
Lifetime Benefit Maximum	\$2,000,000 per person	\$2,000,000 per person \$2,000,000 per person	
Primary Care Physician (PCP)	PCP manages and/or directs all care.	PCP not required.	PCP not required.
Provider Choice	Local Network. Referrals required for care not by Primary Care Physician.	Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.	Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.
Out of Network Care	Must be referred by PCP and pre-approved by Health Plan. Subject to coinsurance and applicable copayments	Subject to deductible, coinsurance and applicable copayments	Subject to deductible, coinsurance and applicable copayments
Out of Area Care	Covered only for initial treatment of medical emergency or if pre-approved by Health Plan. Subject to coinsurance and applicable copayments.	Subject to deductible, coinsurance and applicable copayments	Subject to deductible, coinsurance and applicable copayments
Amounts Above Plan Allowance	Provider to write off	<u>Network</u> Provider to write off <u>Non-Network</u> Member responsibility	<u>Network</u> Provider to write off <u>Non-Network</u> Member responsibility

* These copayments not included in coinsurance maximums. These services may require coinsurance.

Comparison Chart cont.

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network	Preferred Provider Organization (PPO) Preferred Health Systems
Inpatient Services	\$200 copayment per admission, then subject to coinsurance. Copayment does not apply towards coinsurance maximum.	<u>Network</u> \$300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum. <u>Non-Network</u> \$600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum	<u>Network</u> \$300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum. <u>Non-Network</u> \$600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum.
Outpatient Surgery	Subject to \$100 copayment per surgery, then subject to coinsurance. Copayment does not apply to coinsurance maximum	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Ambulance Services	Subject to coinsurance	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Major Diagstic Tests (includes but not limited to: PET Scans, MRI Scans, CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography)	Must be pre-approved by Health Plan. Subject to \$100 copayment per test then subject to coinsurance. Copayment does not apply to coinsurance maximum.	Must be pre-approved by Health Plan <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded & coins.	Must be pre-approved by Health Plan <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded & coins.
Other Outpatient Services	Subject to coinsurance	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Physician Office Visits	Subject to office visit copayment. \$20 for PCP, \$30 for all other office visits. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Physician Hospital Visits	Subject to coinsurance	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Emergency Room Visits	\$75 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	<u>Network</u> \$100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply. <u>Non-Network</u> \$200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	<u>Network</u> \$100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply. <u>Non-Network</u> \$200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.
Urgent Care Facility Visits	\$30 copayment. Copayment does not apply towards coinsurance maximum.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Home Health Care	Services must be pre-approved by Health Plan. Limited to \$5,000 per benefit period. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to \$5,000 per benefit period. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to \$5,000 per benefit period. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Hospice	Services must be pre-approved by Health Plan. Limited to \$7,500/lifetime. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to \$7,500/lifetime. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to \$7,500/lifetime. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.

Comparison Chart cont.

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network	Preferred Provider Organization (PPO) Preferred Health Systems
Surgery/Anesthesia/ Asst. Surgeon	Subject to applicable inpatient or outpatient copayments, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
Physical Rehabilitation Services	Services must be pre-approved by Health Plan. Inpatient limited to 60 days. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Subject to coinsurance.	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. <u>Network</u> Subject to coinsurance	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. <u>Non-Network</u> Subject to ded. & coins.
Durable Medical Equipment	Services must be pre-approved by Health Plan. Subject to coinsurance. Limited to \$5,000 of covered services per person per year.	Services must be pre-approved by Health Plan. Limited to \$4,500 of covered services per person per year. <u>Network</u> Subject to coinsurance	Services must be pre-approved by Health Plan. Limited to \$4,500 of covered services per person per year. <u>Non-Network</u> Subject to ded. & coins.
Inpatient Nervous & Mental/Drug & Alcohol	Subject to inpatient copayment, then subject to coinsurance. Copayment does not apply towards coinsurance maximum. 60-day limit per year.	<u>Network</u> Subject to inpatient copayment, then subject to coinsurance. Copayments do not apply towards coinsurance maximum. 60-day limit per year.	<u>Non-Network</u> Subject to inpatient copayment, then subject to deductible and coinsurance. Copayments do not apply towards coinsurance maximum. 30-day limit per year.
Outpatient Nervous & Mental/Drug & Alcohol	First 3 visits @ 100%, next 22 visits - \$25 copay; additional visits @ 50%	Both in and out-of-network visits will be counted towards the first 25 visits. <u>Network</u> First 3 visits @ 100%, next 22 visits @ \$25 copay, additional visits @ 50%	Both in and out-of-network visits will be counted towards the first 25 visits. <u>Non-Network</u> First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.
Biologically Based Mental Health Conditions	Benefits same as medical conditions for biologically based mental health conditions.	Benefits same as medical conditions for biologically based mental health conditions.	Benefits same as medical conditions for biologically based mental health conditions.
Preventive Care Services (One per calendar year for each service)	Must be provided by network providers. See specific categories below.	<u>Network</u> Preventive Care Allowance = 1st \$300/person covered in full then subject to coinsurance.	<u>Non-Network</u> Not covered.
Well-Woman Care (office visit, PAP smear test, and STD testing as determined to be appropriate by the provider.)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostic tests covered in full.	<u>Network</u> Applies toward Preventive Care Allowance then subject to coinsurance.	<u>Non-Network</u> Not covered.
Mammogram (recommended frequency age 35-39 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Must be provided by network providers. No referral required. Covered in full.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance.	<u>Non-Network</u> Not covered.
Well-Man Care (office visit and PSA blood test)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostics covered in full.	<u>Network</u> Applies toward Preventive Care Allowance then subject to coinsurance.	<u>Non-Network</u> Not covered.

Comparison Chart cont.

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network	Preferred Provider Organization (PPO) Preferred Health Systems
Periodic Adult Physical Exam	Must be provided by PCP. Subject to \$20 PCP office visit copayment. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered.
Dietitian Consultation	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Applies toward Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered	<u>Network</u> Applies toward Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered
Routine Hearing Exam (Hearing aids NOT covered)	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered.
Routine Vision Exam (Refraction Exam for Glasses - Lenses and frames NOT covered)	Limited to one per year. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Applies toward Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered	<u>Network</u> Applies toward Preventive Care Allowance then subject to coinsurance. <u>Non-Network</u> Not covered
Age Appropriate Bone Density Screening	As approved by Primary Care Physician. Covered in full.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan. <u>Non-Network</u> Not covered.	<u>Network</u> Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan. <u>Non-Network</u> Not covered.
TMJ/Orthognathic Surgery	Not Covered under Medical - see Dental	Not Covered under Medical - see Dental	Not Covered under Medical - see Dental
Custom Shoe Inserts	Not Covered - see KanElect	Not Covered - see KanElect	Not Covered - see KanElect
Childhood Immunizations to Age 6	Covered at 100% as required by state mandate.	Covered at 100% as required by state mandate.	Covered at 100% as required by state mandate.
Allergy Testing	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	As approved by Health Plan. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	As approved by Health Plan. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Antigen Administration (desensitization/treatment) - Allergy Shots	As approved by Primary Care Physician. Subject to applicable office visit copayment. Copayments do not apply towards coinsurance maximum.	As approved by Health Plan. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	As approved by Health Plan. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Infertility Treatment (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	As approved and precertified by Health Plan. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.	As approved and precertified by Health Plan. <u>Network</u> Subject to coinsurance <u>Non-Network</u> Subject to ded. & coins.
Gastric Surgery and Other Weight Loss Treatments	Not Covered - see KanElect	Not Covered - see KanElect	Not Covered - see KanElect
Prescription Drug Benefits (Provided by AdvancePCS) Coinsurance and Copayments copayment per perscription plan deductible or coinsurance maximum.	Tier 1: Generic - 20% coinsurance Tier 2: Preferred Brand - 35% coinsurance Tier 3: Special Case Medications - \$75 copayment per perscription Coinsurance/Copay Maximum: Tiers 1, 2 & 3 only - \$2,580 per person per year Tier 4: Non-Preferred Brand and Compounded Medications - 60% coinsurance Tier 5: Lifestyle Medications - Member pays 100% of the discounted price.	Tier 1: Generic - 20% coinsurance Tier 2: Preferred Brand - 35% coinsurance Tier 3: Special Case Medications - \$75 copayment per perscription Coinsurance/Copay Maximum: Tiers 1, 2 & 3 only - \$2,580 per person per year Tier 4: Non-Preferred Brand and Compounded Medications - 60% coinsurance Tier 5: Lifestyle Medications - Member pays 100% of the discounted price.	Tier 1: Generic - 20% coinsurance Tier 2: Preferred Brand - 35% coinsurance Tier 3: Special Case Medications - \$75 do not count towards medical Coinsurance/Copay Maximum: Tiers 1, 2 & 3 only - \$2,580 per person per year Tier 4: Non-Preferred Brand and Compounded Medications - 60% coinsurance Tier 5: Lifestyle Medications - Member pays 100% of the discounted price.
Dental Benefits	Provided by Delta Dental Plan of Kansas	Provided by Delta Dental Plan of Kansas	Provided by Delta Dental Plan of Kansas